

# American Medical Association

Physicians dedicated to the health of America



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October 24, 2003

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Eric J. Hentges, Executive Director  
Center for Nutrition Policy and Promotion  
Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive Room 1034  
Alexandria, VA 22302

Dear Mr. Hentges:

On behalf of the American Medical Association (AMA) and its Minority Affairs Consortium (MAC), we are pleased to provide comments on revisions to the food guide pyramid. We commend the USDA for taking the initiative to reassess the food guide pyramid in light of the obesity epidemic in our country. The AMA MAC is a special interest group of physicians and medical students who advocate for the improvement of minority health.

The AMA is committed to addressing the obesity epidemic as a public health crisis, in particular, because obesity disproportionately affects minorities in our country (JAMA, 2002.) Additional efforts by the USDA to address the obesity issue are needed. The food pyramid guidelines impact the public's dietary knowledge and decision-making and are critical to improving the health of our nation. We offer suggestions below that will make the food guide pyramid more multicultural. As physicians, everyday we witness the adverse health outcomes that result from conditions of overweight and obesity in our patients. Heart disease, stroke, and diabetes are just a few of the conditions that are linked to obesity. Weight and nutrition management can serve as means by which our patients can prevent certain disease states as well as improve their health and well-being.

The following are our suggestions to the Food Guide Pyramid Reassessment Team.

### Appropriateness of the selection of nutritional goals

#### Include ethnic food ingredients in the food guide pyramid

Recent census projections estimate that by 2050, 50% of the US population will be racial or ethnic minority. With an ever-increasing diverse population, nutritional information should reflect, as much as possible, the myriad of ethnic food ingredients that exist in our nation. Including some ethnic food ingredients in the food pyramid such as ghee, bok choy, tofu, lentils, plantains, corn and flour tortillas would reflect foods that are consumed by many Americans but are not reflected in the current food guide pyramid. Additionally, we suggest including more racial and ethnic minorities to participate in your food surveys to reflect the types of foods that are consumed by a variety of Americans to make the food guide pyramid more applicable.

#### Include alternative dairy product options

According to the American Gastroenterological Association, nearly 50 million American adults are lactose intolerant. Certain ethnic and racial populations are more widely affected than others. As many as 75 percent of all African-American, Jewish, Native American, and Mexican-American adults, and 90 percent of Asian-American adults are lactose intolerant. The condition is least common among people of northern European descent. Lactose intolerance is the inability to digest significant amounts of lactose, which is the predominant sugar of

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milk. The difficulty in digesting traditional dairy products may deter many minorities from consuming the recommended servings of traditional dairy products. We recommend including alternative dairy product options in the food guide pyramid such as soy milk, lactose-free milk, goat milk, goat cheese and yogurt in lieu of milk and cheese so those who are lactose intolerant are presented with other dairy options to meet their calcium and protein requirements.

#### Increased consumption of whole grains and fruits and vegetables

The food pyramid suggests 6-11 servings of grains. Most Americans interpret "grains" to mean white bread, white pastas and white rice. We suggest lowering the suggested servings of white bread, rice and pasta and emphasizing an additional food category called "whole grains" that includes wheat pasta, brown rice and whole grain breads. We suggest adding other grains in this section such as rice crackers, rice pudding, naan, corn and flour tortillas, pita bread and tabouleh. Additionally, we suggest that more servings of fruits and vegetables should be emphasized due to the greater nutritional value that can be found in fresh, frozen, canned and dried fruits and vegetables.

#### Appropriate use of sedentary, reference-sized individuals

With a majority of the US population being obese or overweight, using a sedentary life-style guide is a reasonable and appropriate way to guide the reduced daily caloric needs of sedentary adults and adolescents. Sedentary adolescents are missing entirely from the daily caloric guide. We feel adolescents should be included since more adolescents are becoming overweight or obese. A stronger emphasis on physical activity should also be included within the food pyramid guide. A combination of physical activity along with nutritional and dietary guidelines is the most efficient way to maintain a healthier life-style.

#### Appropriateness of using "cups" and "ounces" vs. "serving"

The term "serving size" can be vague and imprecise. Using basic measurements such as "cups" and "ounces" quantifies the serving sizes for the average consumer which facilitates a consistent use of one "serving size." In addition to using "cups" and "ounces," we suggest also using a variety of visual cultural icons to signify one "serving." For example, a deck of cards, 1/2 of a tortilla or 4 strips of grilled meat can be used as visual multicultural icons to represent one "serving."

In conclusion, the AMA and its MAC appreciate the opportunity to provide recommendations to the food guide pyramid. Attached for your reference, you will find current AMA policy that addresses obesity and nutritional guidelines as well as a recently adopted resolution "Obesity and Culturally Competent Dietary and Nutritional Guidelines." Our AMA and its MAC are working on a report and recommendations for its June 2004 policy-making meeting. Feel free to contact me if we can be of further assistance.

Sincerely,



Michael J. Scotti Jr., MD  
Senior VP of Professional Standards

Enclosure

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428  
(A-03)

Introduced by: National Medical Association  
Subject: Obesity and Culturally Competent Dietary and Nutritional Guidelines  
Referred to: Reference Committee D  
(Carol A. Tavani, MD, Chair)

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- 1 Whereas, It is estimated that approximately 61% of all US adults are obese and the obesity rate
- 2 of children and adolescents has doubled since 1970; and
- 3
- 4 Whereas, The obesity rate in minority communities has increased disproportionately in
- 5 comparison to whites in the US; and
- 6
- 7 Whereas, According to the US Department of Agriculture, healthier diets may prevent \$71 billion
- 8 per year in medical costs, lost productivity, and premature deaths caused by four diet-related
- 9 diseases: coronary heart disease, cancer, stroke and diabetes mellitus; and
- 10
- 11 Whereas, Coronary heart disease, cancer, stroke and diabetes mellitus disproportionately affect
- 12 African American, Hispanic and American Indian communities in comparison to other racial and
- 13 ethnic groups in the US and contribute to persistent racial and ethnic health care disparities; and
- 14
- 15 Whereas, The USDA developed *Dietary Guidelines for Americans* and a *Food Guide Pyramid*
- 16 that do not fully incorporate cultural and socioeconomic considerations as well as racial and
- 17 ethnic health disparities as it relates to body weight, diet and nutrition; and
- 18
- 19 Whereas, The American Medical Association entered an ongoing Memorandum of
- 20 Understanding (MOU) with the US Department of Health and Human Services that directly
- 21 supports the goals of *Healthy People 2010* to improve the health of the nation and eliminate
- 22 racial and ethnic health disparities; and
- 23
- 24 Whereas, AMA Policy H-150.953, "Obesity as a Major Health Program," supports working
- 25 "...with appropriate federal agencies, medical specialty societies, and public health
- 26 organizations to educate physicians about the prevention and management of overweight and
- 27 obesity in children and adults, including education in basic principles and practices of physical
- 28 activity and nutrition counseling"; and
- 29
- 30 Whereas, The AMA is also developing a clinical tool, which includes minority health disparities,
- 31 to guide clinicians in assessing and treating adult obesity; and
- 32
- 33 Whereas, *The Journal of Preventive Medicine* 2002:vol 22 reports a high correlation between
- 34 lower income and minority neighborhoods having less access to supermarkets and a greater
- 35 incidence of unhealthy diets than non-minority or higher income neighborhoods; and
- 36
- 37 Whereas, The AMA and its Minority Affairs Consortium, along with the National Medical
- 38 Association and other organizations, have concluded that obesity and its health complications
- 39 contribute to persistent racial and ethnic health care disparities; therefore be it

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- 1 RESOLVED, That our American Medical Association and its Minority Affairs Consortium study
- 2 and recommend improvements to the US Department of Agriculture's *Dietary Guidelines for*
- 3 *Americans* and *Food Guide Pyramid* so these resources fully incorporate cultural and
- 4 socioeconomic considerations as well as racial and ethnic health disparity information in order
- 5 to reduce obesity rates in the minority community (Directive to Take Action); and be it further
- 6
- 7 RESOLVED, That our AMA report its findings and recommendations to the AMA House of
- 8 Delegates by its 2004 Annual Meeting. (Directive to Take Action)

Fiscal Note: No Significant Fiscal Impact

Received: 5/7/03

## RELEVANT AMA POLICY

### H-150.953 Obesity as a Major Public Health Program

Our AMA will: (1) urge physicians as well as managed care organizations and other third-party payors to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99)

### H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; and (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity. (Res. 423, A-98)

### H-350.965 Culturally Effective Health Care

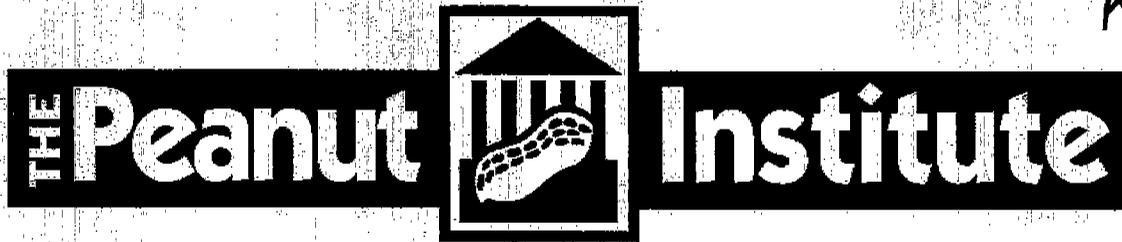
Our AMA renews its commitment to supporting the importance of culturally effective health care in eliminating disparities and to exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. (Res. 718, I-02)

See also:

H-350.967 Eliminating Health Disparities

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Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive  
Room 1034  
Alexandria, Virginia 22302

October 24, 2003

Re: Proposed Daily Food Intake Patterns for Food Guide Pyramid

Dear Food Guide Pyramid Reassessment Team:

Peanuts and peanut butter are unique foods within the "Meat group" in that they provide plant protein, fiber, good unsaturated fat, and many micronutrients and phytochemicals. Usually eaten as a protein source, peanuts and peanut butter are relatively inexpensive foods and are a positive substitute for refined carbohydrates or for saturated fat. For example, peanuts can replace croutons on a salad. Or, peanut butter can be used as a healthful and inexpensive alternative to sandwich items containing higher amounts of saturated fat.

Peanuts and peanut butter are loved by Americans, representing about 80% of the "nuts" eaten in the United States. (1) Nutrition research shows that when peanuts and peanut butter are consumed in small amounts daily, they can help lower cholesterol, reduce the risk of type 2 diabetes, and satisfy hunger. (2-4)

No matter what shape the new Food Guide Pyramid takes, we feel that peanuts and peanut butter should be given special consideration as complex plant foods that:

1. Can be eaten on a daily basis in small amounts;
2. Can be a healthy substitute for refined carbohydrate or saturated fat sources; and
3. Can satisfy hunger without leading to weight gain.

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**Peanuts and Peanut Butter Can Be Eaten Daily in Small Amounts**

As you know, a recent Food and Drug Administration (FDA)-approved qualified health claim says, "Scientific evidence suggests but does not prove that eating 1.5 ounces of most nuts, such as peanuts, as part of a diet low in saturated fat and cholesterol may reduce the risk of heart disease. See nutrition information for fat content." The claim is based on a large body of epidemiological and clinical studies showing a 25-50% reduction in the risk of heart disease when 1 to 2 ounces of peanuts, nuts, or peanut butter are consumed 5 or more times a week. (2)

**Peanuts and Peanut Butter Can Be a Healthy Substitute for Refined Carbohydrate or Saturated Fat Sources**

Peanuts are technically a legume, but are categorized with and consumed like "nuts" in the United States. New uses for peanuts, such as satays, sauces and dips, are becoming more popular. In addition to healthy mono- and poly-unsaturated fat, peanuts contain the most plant protein of any "nut." They also are highest in the amino acid arginine, a precursor to nitric oxide, which helps to dilate blood vessels and improve blood flow.

Researchers from Harvard University report that, "Based on data from the Nurses' Health Study, we estimate that substitution of the fat from one ounce of nuts for equivalent energy from carbohydrate in an average diet was associated with a 30% reduction in CHD [coronary heart disease] risk and the substitution of nut fat for saturated fat was associated with 45% reduction in risk." (5)

Researchers from Harvard also found that consuming a half serving (one tablespoon) of peanut butter or a full serving of peanuts or other nuts (one ounce), five or more times a week is associated with a 21% and 27% reduced risk of developing type 2 diabetes, respectively. The study authors state, "Our findings suggest potential benefits of higher nut and peanut butter consumption in lowering the risk of type 2 diabetes in women. To avoid increasing caloric intake, regular nut consumption can be recommended as a replacement for consumption of refined grain products or red or processed meats." (3)

An FDA report highlights areas where the government intends to focus efforts on providing better nutrition and health messages to consumers, including: "The benefits of substituting nuts for other sources of saturated-fat-containing protein to help reduce the risk of heart disease." (6)

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Peanuts and peanut butter are plant protein sources that bring along good unsaturated fat, as well as many other beneficial micronutrients. Peanuts are a good source of fiber, vitamin E, folate, potassium, magnesium, and zinc, all of which are thought to be important to health. Peanuts and peanut butter also contain bioactive components such as resveratrol, beta-sitosterol, flavonoids, and antioxidants.

### **Peanuts and Peanut Butter Can Satisfy Hunger Without Leading to Weight Gain**

Research from Purdue University shows that snacking on peanuts and peanut butter is an effective way to control hunger without leading to weight gain. Following a snack of peanuts or peanut butter, the participants' hunger was reduced for two and a half hours. When participants were fed typical portions of high-carbohydrate snacks, hunger returned within a half hour. (4)

A recent review paper on nut consumption and body weight concludes, "The available data demonstrate that nut consumption among free-living individuals is not associated with higher BMI [body mass index] compared with non-nut consumers despite the fact that nuts are fat- and energy-dense foods." (7)

Further, a free-living study at Harvard School of Public Health shows that participants who followed a calorie-controlled, moderate-fat diet (35% of calories from fat) with peanuts and peanut butter were able to lose more weight and keep the weight off longer than those following a calorie-controlled, low-fat diet (20% of calories from fat). (8)

In summary, we urge you to consider the following points:

1. Peanuts and peanut butter can be eaten on a daily basis in small amounts, not only as a protein source, but as a source of healthy fats, fiber, vitamins, hard-to-get minerals, phytochemicals and antioxidants;
2. They can be a healthy substitute for refined carbohydrate or saturated fat sources; and
3. Peanuts and peanut butter can satisfy hunger without leading to weight gain.

Thank you for your efforts.

Sincerely,

*John T. Powell*

John T. Powell, President  
The Peanut Institute

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References:

1. *Federal Register*. September 11, 2003. Vol. 68, No.176.
2. Kris-Etherton, P.M., et al. The effects of nuts on coronary heart disease risk. *Nutrition Reviews*. 2001;59(4):103-11.
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4. Mattes, RD and Kirkmeyer, SV. Effects of food attributes on hunger and intake. *International Journal of Obesity*. 2000;24:1167-75.
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7. Sabate, J. Nut consumption and body weight. *American Journal of Clinical Nutrition*. 2003;78(suppl):647S-50S.
8. McManus, K., et al. A randomized controlled trial of a moderate-fat, low-energy diet compared with a low-fat, low-energy diet for weight loss in overweight adults. *International Journal of Obesity*. 2001;25:1503-11.

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October 22, 2003

Dr. Eric Hentges  
Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy & Promotion  
3101 Park Center Drive  
Room 1034  
Alexandria, VA 22302

Dear Dr. Hentges:

The Sugar Association (Association) is pleased to submit comments on the proposed revision of the U.S. Department of Agriculture, Center for Nutrition Promotion and Policy's (CNPP) Food Guide Pyramid. The Association commends the Federal Government for its concerns about the health and well-being of the American public, and acknowledges the dedication of those working hard on Americans' behalf. The Association believes today's public health challenges require innovative strategies and contemporary initiatives when educating the American public about healthful eating and active lifestyles.

The Association would like to comment on two specific questions cited as of particular interest to CNPP.

**Question 3: "Appropriateness of the proposed food intake patterns for educating Americans about healthful eating patterns."**

It is impossible to comment explicitly on the scientific validity of the proposed dietary intake suggestions. The body of scientific evidence underpinning the proposed dietary patterns has not been made available for public examination. Thus, the Association offers the following observations for CNPP deliberation:

- There is no evidence that the proposed eating patterns are based on true scientific consensus.
- It is impossible to determine if the proposed eating patterns are based on outdated data that contradict the current body of science, or are derived from the extrapolations and assumptions of the developers.
- Proposed serving sizes and, more importantly, serving numbers do not accurately characterize what the American public perceives as real-life food portions.
- The current Food Guide Pyramid is so overly prescriptive and has required multiple, detailed accompanying materials to be developed in efforts to effectively educate the consuming public and every indication is that the new Pyramid will require similar materials making it less effective.

**Be Sure It's Sugar: The Natural Sweetener... 15 Calories Per Teaspoon!"**



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The Association sees value in a visual representation of scientifically verifiable, consensus-based dietary guidance that gives emphasis to active lifestyles and the increased consumption of fiber and nutrient-dense foods.

We also believe it would be more constructive in today's environment if the literature accompanying the Food Guide Pyramid would help consumers understand what a proper portion size is, whether they are eating fruit, vegetables, grains, meat, dairy items, fast food or dessert. This approach would provide a practical tool to help Americans eat less food. The diets of the American public are very diverse and so is the diversity of opinion among the scientific and nutrition community about what constitutes a healthful diet. However, all agree on one thing - the major health concern facing the American public is overeating.

**Question 2: "Appropriateness of the selection of nutritional goals", specifically "Nutritional Goals for Added Sugars."**

First, the Association would like to call attention to the fact that the term "moderation" cited in the *Federal Register* Notice, which is the advice contained in Dietary Guidelines for Americans, is so often ignored in current nutrition debates and advisories. The term "moderation" is not synonymous with "limit" or "restrict."

The Association firmly believes that the American public is better served by nutrition advice that is able to withstand the scrutiny of the entire body of science, no matter the issue. The Association is on record as a critic of the current Food Guide Pyramid due to the fact that its added sugars consumption suggestions are based on mathematical formulas, not on scientific consensus. This mathematical model is once again the paradigm for the proposed revision of the Food Guide Pyramid in spite of the very extensive scientific review by the National Academy of Science, Institutes of Medicine, (NAS, IOM) which concluded:

- "Based on the data available on dental caries, behavior, cancer, risk of obesity, and risk of hyperlipidemia, there is insufficient evidence to set a UL for total or added sugars."

The NAS, IOM report states unequivocally,

- "There is no clear and consistent association between increased intakes of added sugars and BMI." (Emphasis added)

In fact, every comprehensive review of the scientific literature continues to exonerate sugars intake involvement in any lifestyle disease, including obesity. The current NAS, IOM report found that selective nutrient displacement was observed in some sub-populations only after their intakes of added sugars exceeded 25% of their daily calories, which is well above current USDA estimates.

Second, the Association questions the scientific validity of the suggested added sugars servings in the previous as well as the proposed Food Guide Pyramid and its accompanying literature. The Food Guide Pyramid is the primary public reference for the

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term "added sugars" and gives an unwarranted credibility to, and implied endorsement of, the current negative emphasis on sugars intake. These calculated serving suggestions are used as the primary basis for misrepresenting the impact of sugars intake on the health of the American public.

The Association respectfully requests that CNPP consider the reality that the current negative emphasis on sugars intake may have the same unforeseen consequences as the simplistic dietary advice to singularly limit dietary fat. Obesity rates have only increased throughout the "low-fat" decade of the 1990s.

Furthermore, the eating patterns suggested in the Food Guide Pyramid do not reflect the realities of food fortification. When fortification is ignored, more servings of most food groups are required to achieve recommended nutrient intakes. Much of the recent criticism of the current Food Guide Pyramid correctly identifies consumer confusion between the recommended number of servings and what the average person thinks is a serving size. This confusion has had the unintended consequence of Americans believing they are allowed to consume too much food.

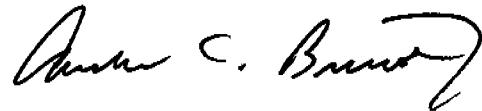
The present CNPP mathematical model, which automatically means more servings and more calories are required, artificially lowers the number of calories that are allotted to the so-called "added sugars." Consumers have the impression that this is a recommendation based on science, not the result of a well intended but imperfect formula.

The continued emphasis on "added sugars" in the absence of any valid scientifically verifiable health implications will only further obscure the real issue: if one consumes more calories—no matter the source—than one burns, weight gain is inevitable.

Third, the Food Guide Pyramid has not undergone independent, external scientific or medical peer review. The responsibilities of the 2005 Dietary Guidelines Advisory Committee are already extensive. The current plan to simply tack a review of the Food Guide Pyramid's planned revisions to the duties of the current Dietary Guidelines Advisory Committee generates a question as to the thoroughness of such a review process.

The Association asks that CNPP take into consideration these comments in its effort to develop an effective educational tool to assist the American public getting back on the track of good health and well-being.

Sincerely,



Andrew C. Briscoe  
President

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HARVARD SCHOOL OF PUBLIC HEALTH

Department of Nutrition

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10/27/03

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October 24, 2003

Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

To Food Guide Pyramid Reassessment Team:

We appreciate the opportunity to comment on the proposed revision of the Food Guide Pyramid.

Overwhelming evidence from controlled feeding studies, randomized clinical trials, and epidemiological studies indicate that the Food Guide Pyramid is in need of fundamental revision. The core message of the current dietary pyramid, that all fats and oils should be used sparingly and that starches should be consumed in large amounts, has never had clear scientific support and is inconsistent with studies from at least 40 years ago showing opposite effects of various types of fat on blood lipid levels. Empirical evidence has shown that individuals who adhere to the guidance of the Food Guide Pyramid (as expressed in the Healthy Eating Index) do not enjoy the expected health benefits [McCullough ML et al, Am J Clin Nutr 2002;76:1261-71]. Alternative recommendations, based on a rational interpretation of available data, in contrast, do appear to provide health benefit. Moreover, increasing evidence suggests that the emphasis on high carbohydrate intake, including large amounts of refined starch has contributed to the epidemic of obesity, and other adverse health outcomes, without improving health. These issues are discussed in some detail in a recent article by Willett and Stampfer MJ. [Rebuilding the food pyramid. Sci Am 2003;288:64-71]. More detailed references are provided in the citations from that article.

It is certainly reasonable to solicit suggestions, but we urge that revision of the Pyramid be delayed until after the conclusion of the work of the newly constituted Advisory Committee for the U.S. Dietary Guidelines. Logically, the Pyramid should provide the consumer oriented expression based primarily on those guidelines. As the Advisory Committee has just met for the first time, it is simply premature to develop the revised pyramid concurrently. The nature of the topics of particular interest to the Center for Nutrition Policy and Promotion (CNPP) for comments suggests that only minor tinkering with the Pyramid is contemplated. This would be a major disservice to the American people and for the cause of public health. The Pyramid has largely failed in its stated mission, and requires complete restructuring.

We offer the follow comments on the specific "topics of interest":

**1. Appropriateness of using sedentary, reference-size individuals in assigning target caloric levels:**

Although weight control is a top priority, setting target calorie levels is likely to be a useless exercise. For total calories, the obvious goal for individuals at ideal weight is to balance caloric

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intake with caloric expenditure. For overweight individuals, caloric expenditure should exceed caloric intake until ideal weight is attained. This balance can be measured with exquisite accuracy by assessing weight and weight change. A related issue is the change in adiposity, independent of body weight. This is best reflected in waist circumference. Again, consumers can see this easily. In contrast, neither typical consumers nor nutrition practitioners can estimate either caloric intake or caloric expenditure with sufficient precision to calculate caloric balance. Also, it is unrealistic to assume that Americans can or will constantly tally up their caloric intake or measure their food intake in ounces or fractions of cups. The primary goal of a food guide graphic should be to convey which foods should be emphasized and which should be minimized for optimal health. Energy balance will need to be monitored primarily by assessing weight and weight change. Thus, we suggest that the proposed detailed stratification by energy requirements not be introduced unless the USDA can provide clear evidence that this will assist people in long-term weight control. Otherwise, is it likely to cause confusion and distract attention from the importance of healthy food choices.

We do encourage that the revised graphic carry a message about the importance of increasing physical activity, reducing physical inactivity and weight control.

## 2. Appropriateness of the selection of nutritional goals:

The selection of nutritional goals in general, and the principles proposed are sensible, but some of the examples provided are not.

### 2.1 *Trans Fat*

The most egregious nutritional goal regards *trans* fat. The material states, "an intake goal for *trans* fat was not set because no quantified standard is provided..." This is simply untrue. The recent IOM report on macronutrient intake states explicitly that the goal for *trans* fat is to eat as little as possible. Indeed, wording to this effect has now been added to the new nutrition label including *trans* fat, which has been set forth by the FDA. Reducing *trans* fat, and eliminating its major source (partially hydrogenated vegetable oils) is probably the easiest way to improve nutrition available to our country. Substitutes are available for virtually every product that contains *trans* from partially hydrogenated oils. The cost differential is small, and even the most conservative estimates suggest a large health benefit. Indeed, such a cost effectiveness analysis was the basis for the Office of Management of Budget to prompt the FDA to issue rules for the new nutrition label that includes *trans* fat. The evidence for harm from *trans* fat is incontrovertible, based on many randomized trials. Compared to the oils from which it is derived, partially hydrogenated fat has clear adverse effects on lipids linked to risk of heart disease. Furthermore, strong evidence suggests other adverse effects. Hence, it is simply unconscionable that the CNPP does not plan to provide information about limiting consumption of *trans* fats in materials designed for consumers. To the contrary, the ultimate product should provide clear guidance for consumers to replace sources of saturated and *trans* fat with sources of non-hydrogenated unsaturated fatty acids.

### 2.2 *Vitamin E:*

The goal of the Pyramid is to change the American diet to more healthy patterns of eating. It is not meant simply to reflect the current typical American diet. A healthy diet can meet the new RDA levels for vitamin E as specified in the 2000 IOM report on Dietary Reference Intakes through

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sensible choices of foods rich in vitamin E, principally those rich in vegetable oils. Likewise, the CNPP did not consider it feasible to specify the use of nuts and seeds to meet the RDA since they contribute only 4% of the total vitamin E in American diets. This is precisely the point. A healthy dietary pattern should include greater consumption of nuts and seeds. Indeed, among the individual foods studied in epidemiologic investigations, nuts consistently emerge as among the most healthful food items.

### 2.3 *Added sugars:*

Any sensible dietary advice will sharply limit added sugars. This recommendation is not based on just the harmful effect of sugar per se, which includes exacerbation of the insulin resistance syndrome, but also the adverse effect of additional calories without other nutrients (empty calories).

### 3. **Appropriateness of the proposed food intake patterns:**

The proposed patterns here exemplify and illustrate the earlier comment regarding small tinkering with the Pyramid as opposed to the necessary full-scale revision. Intake of refined carbohydrates (including added sugars) should be sharply curtailed. The current advice, maintained in the proposed revisions, calls for 6-11 servings of carbohydrates per day. The call for an increased proportion of that in the form of whole grains is laudable, but does not go far enough. Even if three or four servings of whole grains are included in the recommendations, the current levels of carbohydrate would still imply that three to nine servings of refined starch is desirable. Refined starches do not have documented health benefits, but like sugar exacerbate the insulin resistance syndrome and are a major source of empty calories. Thus, they should be included in the foods to be used sparingly. Further, certain root and starchy vegetables, such as potatoes and corn are more nutritionally similar to grains than green leafy, orange/yellow or cruciferous vegetables that have been associated with reduced risks of cancer and cardiovascular disease. Thus, they would be better placed in the grains group and relabeled "grains and starchy vegetables". As noted above, the advice on fats is also inadequate. Many Americans consume inadequate amounts of healthful fats probably in part because of poor nutritional advice provided by our government. A clearer distinction of the kinds of fats is mandatory.

The proposed revision of the food guide pyramid continues to lump meats, eggs, nuts, and legumes together as the "protein" group. Although these food groups are all high in protein, the health effects of these foods are distinctly different. Convincing epidemiologic and clinical evidence indicates that higher consumption of fish is protective against heart disease, whereas a higher consumption of red and processed meats increases risk of heart disease, type 2 diabetes, and probably colorectal cancer. Also, plant-based foods (including nuts, peanuts, beans, and peas) are not only excellent sources of protein, but also rich sources of healthy fats, antioxidants, minerals, fiber, and phytochemicals. Thus, it makes more sense to separate different sources of protein in the food guide pyramid. Specifically, fish and poultry should be separated from red meat. Nuts and legumes should be placed together or closer to other plant-based foods such as fruits, vegetables, and whole grains.

Also, the current Pyramid and examples in the proposed revision imply that high dairy consumption is an essential part of a healthy diet. This is likely to be driven by the extremely high calcium RDA and the assumption that this must be met by foods. The validity of this RDA itself is questionable;

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interestingly the U.K. more recently reviewed the available evidence and concluded that the RDA should be 700 mg per day for all persons over 19 years of age. Further, a large body of data indicates that persons consuming high amounts of dairy products do not have appreciably reduced fracture rates, and in many studies high consumption of dairy foods has been associated with advanced prostate cancer and ovarian cancer. Thus, we cannot assume that this is safe. The recommendations also ignore the fact that a substantial percentage of the U.S. adult population cannot tolerate high dairy product consumption due to lactose intolerance. At a minimum, the recommendations should clearly indicate that calcium supplements, calcium fortified soy milk or 100% juices are alternative sources of calcium.

**4. Appropriateness of using cups and ounces versus servings in consumer materials to suggest daily amounts to choose from each food group and sub-group:**

Given the current super-sizing phenomenon in food service establishments and the natural individual variation of serving/portion size, it is important to give guidance on reasonable quantity of consumption. Effective communication for the general public is especially critical because they do not have a good grasp of what quantity of food is considered a reasonable serving size. The new design needs to be flexible enough to be applicable for people with different energy needs, and yet able to convey quantity clearly. In addition, any reference to serving size should be consistent with what is being used by the FDA as these are what consumers will see on food labels.

In summary, we strongly urge the CNPP to redirect their efforts toward a complete revision of the Food Guide Pyramid based on available scientific data, and free from the influence of the food industry. The goal should be promoting the health of Americans, not the commercial interests of food product providers. We do appreciate that a revision of the Food Guide Pyramid is being considered, and we are prepared to work with the CNPP to evaluate the potential health consequences of draft guidelines (or indices based on them, such as the Healthy Eating Index) using the large prospective databases that we have developed.

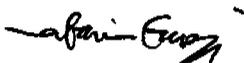
Yours sincerely,



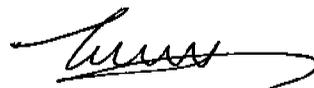
Alberto Ascherio, M.D., Ph.D.  
Associate Professor



Lilian Cheung, Sc.D., R.D.  
Lecturer, Director of Health Promotion and  
Communication



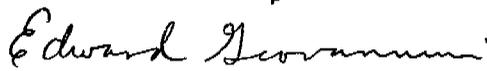
Wafie Fawzi, Dr.P.H.  
Associate Professor



Teresa Fung, Sc.D., R.D.  
Adjunct Assistant Professor



Matthew Gillman, M.D.  
Associate Professor



Edward Giovannucci, M.D., Sc.D.  
Associate Professor

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*Frank Hu*

Frank Hu, M.D., M.P.H., Ph.D.,  
Associate Professor

*David Hunter*

David Hunter, Sc.D.  
Professor

*Karen Peterson*

Karen Peterson, D.Sc.  
Associate Professor, Director of Public  
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*Clifford Lo*

Clifford Lo, M.P.H., Sc.D.  
Assistant Professor

*W. Allan Walker*

W. Allan Walker, M.D.  
Professor

*Eric Rimm*

Eric Rimm, Sc.D.  
Associate Professor

*Frank Sacks*

Frank Sacks, M.D.  
Professor

*Meir Stampfer*

Meir Stampfer, M.D., Dr.P.H.  
Professor

*Marianne Wessling-Resnick*

Marianne Wessling-Resnick, Ph.D.  
Professor

*Walter Willett*

Walter Willett, M.D., Dr.P.H.  
Professor, Chair



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October 24, 2003

Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

**Attention: Members of the Reassessment Team**

The Dairy Council of California commends the USDA for recognizing the vital role milk and dairy play in a balanced, daily diet and strongly supports the continued placement of milk and dairy as major food group within the food guide pyramid.

Milk and dairy products contain nine essential nutrients and are the number one source of calcium and vitamin D. In fact, milk and dairy products provide about 70 percent of calcium consumed in the American diet; yet calcium is a primary nutrient lacking in the diets of more than two-thirds of American adults. The statistics are particularly concerning for children who are consuming far below the daily recommended intake of 800-1,300 mg per day. In fact, nearly nine out of 10 teenage girls and seven out of 10 teenage boys fail to get the recommended amount of calcium in their diets.

Two new reports confirm the importance of children's calcium intake for strong bones. A *Journal of the American Medical Association* study reports a significant increase in the incidence of forearm fractures in adolescents during 1999-2001 compared to 30 years prior, citing poor calcium intake during peak bone growth periods, change in physical activity or both as the contributing factor. Another study in the *Journal of the American Dietetic Association* showed that adolescent boys who consumed three servings of milk a day had increases in bone density twice as great as those who drank juice; the same boys had higher intakes of calcium, vitamin A, vitamin D. These two studies reinforce the concern that if children fail to consume enough calcium during peak growing years, they may be faced with the possible consequences of weaker bones during adolescent and teen years.

While some oppose dairy's role in the food guide pyramid and advocate the use of supplements or fortified products, the Dairy Council strongly discourages against this

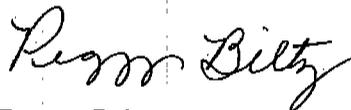
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position. Calcium-fortified beverages and supplements may provide adequate amounts of calcium, however, these alternatives do not compare to the nutrient-rich package dairy offers. Also, milk is the most common food source containing vitamin D, which is essential for optimizing calcium absorption. The nutrients in dairy products have protective factors that help prevent diseases and conditions including high blood pressure, osteoporosis, rickets and certain cancers. More recently, emerging science shows a strong connection between weight loss and calcium intake specifically from dairy products. Supplements and calcium-fortified products do not offer the same host of benefits.

In closing, I want to reiterate again the importance of a food guide pyramid in which milk and dairy products are recognized as part of healthy, balanced diets for all Americans.

Please contact me should you have any questions at \_\_\_\_\_ Thank you.

Sincerely,



Peggy Biltz  
Chief Executive Officer  
Dairy Council of California



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In particular, NPA supports the Center's reliance on Dietary Reference Intakes (DRIs) established by the National Academy of Sciences Institute of Medicine (IOM). NPA agrees that nutritional goals for the daily food intake patterns that form the basis for the Pyramid should be based, as applicable, on the Recommended Dietary Allowances (RDAs) and the Acceptable Macronutrient Distribution Ranges (AMDRs) established by the IOM. With specific regard to carbohydrate, the IOM has established (1) an RDA of 130 g for most adults (excluding pregnant and lactating women, for whom RDAs of 175 g and 210 g, respectively, were established) and children over the age of two, and (2) an AMDR of 45 to 65% of calories. The 130 g RDA for carbohydrate is based on the amount of carbohydrate utilized by the brain, which uses carbohydrate (in the form of glucose) almost exclusively for its energy needs; the AMDR for carbohydrate represents the proportion of carbohydrate in the total diet that the IOM believes best promotes health and minimizes the risk of chronic disease. These authoritative recommendations confirm the continued importance of carbohydrate-containing foods, including pasta, in human nutrition, and are appropriately used as nutritional goals for food intake patterns.

NPA also agrees with the Center that the proposed intake patterns, as reflected in Table 5, Nutrients in Proposed Intake Patterns, are consistent with the IOM's quantitative recommendations for carbohydrate intake. NPA is concerned, however, that the intake patterns reflected in the proposed materials are not sufficiently detailed to serve as useful guides to informed food choices. The proposed patterns identify the recommended number of servings from the grains group for twelve target calorie levels, and divide grains into two subgroups: whole grains, and other grains. The proposed patterns also provide examples of foods in each subgroup, but do not provide any further context about the diversity of carbohydrate-containing foods or the importance of such foods in the daily diet.

NPA believes that, if the proposed intake patterns and corresponding food groups are to be used to their full potential as education tools, the following measures are necessary:

- To offset the proliferation of fad diets that seek to cast healthful carbohydrates in a negative light, materials accompanying food intake patterns should emphasize that carbohydrates in grains, fruits, vegetables, and dairy are desirable and recommended for consumption as part of a balanced diet.
- The current Pyramid and proposed intake patterns do not adequately convey the diversity of carbohydrates or the beneficial attributes of certain types of carbohydrate-containing foods, such as pasta. To better educate consumers about the diversity of carbohydrates, the nutritional benefits of particular forms of

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HOGAN & HARTSON, L.L.P.

carbohydrates should be highlighted. For example, whole grains may contain fiber and antioxidants and may reduce the risk of heart disease and some cancers. The carbohydrates in pasta and certain other foods have a low glycemic effect and may be useful in promoting satiety and long-lasting energy.

- Whole grain pasta should be added as an example in the whole grains subgroup.
- Materials accompanying any illustrative food patterns used in consumer educational materials must make clear that each pattern represents simply one example of a healthful intake pattern at a particular calorie level. The proposed intake patterns contain carbohydrate at 52 to 59% of calories, but the IOM recommendations allow for carbohydrate consumption at levels up to 65% of calories. Thus, the proposed intake patterns do not represent the only appropriate patterns at the identified calorie levels.
- NPA supports the creation of additional intake patterns to reflect a greater variety of caloric intakes. The proposed pattern based on 1000 total calories, however, is unrealistic for most consumers and should be removed.

\* \* \* \* \*

NPA appreciates the Center's consideration of these comments and looks forward to participating further in the Pyramid reassessment process.

Sincerely,



Gary Jay Kushner  
Counsel to National Pasta Association

1. Foster-Powell, et al., 2002. International Table of Glycemic Index and Glycemic Load Values: 2002. Am. J. Clin. Nutr. 76:5-56.

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**American Dietetic Association**  
**Your link to nutrition and health.<sup>SM</sup>**



October 25, 2003

USDA Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive  
Room 1034  
Alexandria, VA 22302

Dear Dr. Hentges:

The American Dietetic Association (ADA) appreciates the opportunity to provide input to the revisions of the USDA Food Guide Pyramid in this first phase of the process. The USDA Food Guide Pyramid is a vital public health education tool, and it is paramount that it be based in strong science and developed with consumer understanding and application in mind. ADA is committed to providing feedback based on sound scientific evidence and significant scientific agreement.

**Table 1: Proposed Daily Food Intake Patterns.**

**Q: Appropriateness of using "cups" and "ounces" versus "servings" in consumer materials to suggest daily amounts to choose from each food group and subgroup.**

Consumers have a difficult time interpreting servings vs. volume or weight measures. ADA appreciates that USDA is looking to determine which approach may make the most sense to consumers. Given the interrelationship between the USDA Food Guide Pyramid and food labels, ADA recommends that to the extent possible the portions on the pyramid to be congruent with those listed on food labels so as to maximize consumer understanding. Further, ADA suggests that the recommendations on the pyramid be based on amount of reference foods or their equivalents rather than the traditional language of "servings." In other words, were the dairy recommendation to remain the same, the ADA would prefer the goal being, "Drink 2-3 8-ounce cups of lowfat milk or the equivalent per day" rather than the current "Consume 2-3 servings of dairy per day." The subtext would then define what portions constitute equivalent servings of milk rather than defining what a serving is. This method has the additional advantage of allowing pyramids to be enhanced for ethnic groups by including a more comprehensive list of equivalents without burdening the visual impact of the pyramid.

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ADA acknowledges that choosing reference foods for each category may be a daunting task – particularly in groups such as grain where the foods vary widely. In those cases ADA recommends market testing several sample reference foods to determine what is most valuable and practical to consumers.

**Q: Appropriateness of the proposed food intake patterns for educating Americans about healthful eating patterns. Are the proposed patterns reasonable intakes to expect for the various age/gender groups? Is the proposed intake of some food groups or subgroups feasible?**

The ADA is concerned that many of the meal patterns - particularly those at lower calorie levels - would not provide adequate micronutrients to many subgroups in the population. ADA realizes that those calorie levels may not be intended for adolescent and adult populations, but, given the current rates of obesity and the trend toward calorie restrictive diets, it is imperative that any consumer materials make clear that these meal plans do not necessarily meet the DRI for vitamins and minerals for many subgroups. For instance, neither adolescent nor menopausal females would meet their calcium recommendations utilizing any of these meal patterns. Likewise, any adolescent or adult following calorie meal patterns below the 1200 level would be unlikely to ingest adequate levels of vitamins B, C, D, and E, calcium, phosphorus, or zinc. The ADA recommends additional servings of certain key foods such as dairy and vegetables be recommended for adult use of the lower calorie meal patterns or that special recommendations for adolescents and adults accompany the graphic. The recommendations should indicate that anyone attempting to restrict caloric intake should focus on choosing nutrient dense and fortified foods and may need to supplement their food intake with a multi-vitamin/multi-mineral supplement.

Finally, ADA strongly believes that one of the USDA Food Guide Pyramid's great strengths is that it is anchored to usual and typical American food consumption patterns. It has always been intended to help people meet their nutrient needs to the extent possible within the confines of their usual eating patterns. To that end it is a feasible and user-friendly tool for educators, health professionals, and consumers. It is crucial that these patterns be based on the most current national food intake data available to continue its tie to actual American eating patterns. It is also crucial that these patterns take into account cultural and ethnic eating pattern differences to make sure that all Americans can utilize the tool effectively.

#### **Table 2: Energy Levels for Proposed Food Intake Patterns**

**Q: Appropriateness of using sedentary, reference-sized individuals in assigning target calorie levels for assessing the nutritional adequacy and moderation of each food intake pattern.**

The ADA agrees with using the DRI as the basis for recommended calorie levels for each population and with the CNPP decision to use sedentary individuals in each age and sex group as the reference individuals. Overestimating usual energy needs should be avoided.

The ADA is concerned, however, with the use of "sedentary, low active, and active" as the three labels of activity levels. These designations would likely be confusing to consumers since the

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common vernacular for activity levels does not match the definitions in the DRI. In other words, people who walk approximately 1 mile per day consider themselves to be low active rather than sedentary. Likewise, someone who walks 2.5 miles or 5000 steps/day generally considers him or herself to be moderately active rather than low active. Thus, ADA recommends renaming the categories to eliminate confusion. To that end, ADA recommends naming them exactly what they are: "Less than 1.5 miles of activity per day, 1.5-3 miles of activity per day, and 3 or more miles of activity per day." Given the recent trend toward and ease of step counting this could be termed as, "< 3000 steps/day, 3-6000 steps/day, and 6000+ steps/day."

The ADA would also like to emphasize that, as these calorie goals for different activity levels illustrate, combining activity with eating is imperative for improving the health of Americans. The ADA strongly recommends that the updated USDA Food Guide Pyramid or equivalent educational tool incorporate activity recommendations to emphasize the balance between nutrition and activity in the overall health picture.

### **Table 3: Nutritional Goals for Proposed Daily Food Intake Patterns**

#### **Q: Appropriateness of the selection of nutritional goals for the daily food intake patterns?**

The ADA is supportive of using the DRI along with emerging science as the basis for these nutrient goals. Vitamin D is absent and must be addressed, especially in light of the re-emergence of rickets among young children and elder adults. The ADA would also like to recommend that you consider iodine intakes. The accompanying materials to the USDA Food Guide Pyramid must include advice on incorporating fortified foods, very rich food sources, supplements, etc. for nutrients that are low in the food supply including vitamin D, vitamin B12 in elders, iron, zinc, iodine, and calcium.

### **Table 4: Nutrient Profiles of USDA Food Guide Pyramid Food Groups and Subgroups**

ADA recognizes that the CSFII '94-'96 and '98 are the best comprehensive datasets currently available. However, ADA believes that these datasets and their analysis are likely an inaccurate representation of both the current food supply and the current eating habits of American families. The past ten years have included significant changes in the food supply, such as fortification with folic acid and calcium. Thus, the food databases used to analyze the intake data are not in line with the current food supply. Secondly, American eating habits have also changed markedly over the past 10 years. With increased dependence on quick and fast food, increased portion sizes, and other trends, it is entirely possible that '94-'96 data are not providing an accurate picture of today. Thus, the ADA strongly recommends that the food composition databases be updated and that more current food consumption data be analyzed. If a more up-to-date and equally comprehensive dataset were to become available during the revision period, ADA would recommend reevaluating these nutrient profiles using the most current data. For example, the data should be compared with latest NHANES data now available.

(The current reliance on outdated data underscores the importance of adequately funding nutrition-monitoring activities such as CSFII. The chronic under-funding of CSFII has resulted in the current data deficit with which we are now working. Fully funding CSFII and all of its

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components including the Diet, Knowledge, and Health survey is critical to the integrity of this project and future nutrition education initiatives.)

#### **Table 5: Nutrition in Proposed Intake Patterns**

**Q: Section of appropriate illustrative food patterns for various consumer materials. For development of consumer materials, what criteria should be used to select a smaller number of illustrative food intake patterns? Which subsets of patterns would be most useful for various audiences?**

The ADA supports using smaller subsets of patterns to address specific audiences. Similar to the volume versus serving size debate, ADA would like to see the subsets synchronized with the FDA Nutrition Label such that people could find their recommended calorie levels as a category on the label. ADA recognizes that the label is also being reviewed. Therefore, ADA recommends coordination with FDA in order to link the two educational tools.

In regards to which patterns should be chosen, ADA recommends choosing a reference adult female, reference adult male, and reference elder adult *need* rather than choosing patterns reflective of average *intake*. It would not be advisable in our current obesity epidemic to use average intake as a benchmark for calorie intake. Rather, we should base recommendations on average need. Other subsets of recommendations should then be developed for children, adolescents, pregnant women, and adults aiming to lose weight. Stressing that these are special populations requiring more or fewer calories may help people recognize that the primary meal patterns are only relevant to modestly active healthy adults.

The most recent DRI equations for estimated energy requirements should be used to determine energy needs for women and men. However, the DRI reference adults – 19-year-old healthy weight males and females – should not be used as the reference individuals for illustrative food intake patterns. The DRI estimates for energy needs of sedentary reference adults are above 2000 calories/day, but many adults actually require fewer calories to maintain their weight. Given that energy needs decline with age and that overweight is a major health issue in the US, it would not be advisable to use the higher calorie levels needed by 19 year olds to represent the average caloric needs for all adults. Thus, ADA asks that the model calorie levels be based on estimates of energy requirements for average age adults rather than those of 19-year-olds.

ADA appreciates the opportunity to offer comment on this important public health tool. ADA encourages continuing and strengthening the use of evidence based reviews as well as expert judgment for developing information to inform the process.

Sincerely,



Marianne Smith Edge

President, The American Dietetic Association

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**OLDWAYS  
PRESERVATION TRUST**

The food issues think tank - promoting healthy, traditional and sustainable food choices

October 24, 2003

Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
Room 1034  
3101 Park Center Drive  
Alexandria VA 22302

Dear Team Members,

Thank you for the opportunity to comment on the process for revising the Food Guide Pyramid; we agree with you that an update is badly needed.

Oldways is the "nonprofit food issues think tank" that has also developed food guide pyramids for consumers. Most widely known in western cultures is our "gold standard" Mediterranean Diet Pyramid, but in other cultures our Asian Diet Pyramid, our Latin American Diet Pyramid, and our Vegetarian Diet Pyramid are also well known. These food guide pyramids have been acknowledged by the CNPP; see, for example, *Nutrition Insights 2, April 1997, Are All Food Pyramids Created Equal?*

In this context we have the following specific comments on the process for revising the Food Guide Pyramid; they are numbered as per Part V of the Notice in the Federal Register, September 11, 2003, p. 53536 et seq.

1. We support the use of sedentary reference-sized individuals in assigning target calorie levels, on the condition that it be made clear in accompanying plain and specific language that sedentary individuals bear significantly higher risks for chronic diseases than active individuals. In other words, the language used to describe this "sedentary reference-sized individuals" approach must take great care not to encourage or license sedentary behaviors.
2. The selection of adequacy and moderation goals in Table 3 appears proper and consistent with the IOM, with one single glaring and quite astonishing oversight. CNPP has an unmistakable public health obligation to set an intake goal for trans fats; the goal should be "to avoid trans fats." The FDA has announced that information on trans fats will soon be included on Nutrition Facts Labels; the nutrition science consensus indicates no safe level for trans fats; and the 2000 Dietary Guidelines for Americans urges Americans to be "cutting back on ... trans fats." Consequently, a stern instead of tepid admonition about avoiding trans fats is the proper course for CNPP. Not to take this step is to put CNPP's entire Food Guide Pyramid review process at risk of failed credibility for ignoring the obvious.
3. The new CNPP approach to proposed food intake patterns is a welcome advance; these alterations appear to be tied directly to the current science and consistent with virtually all other guidelines in wide consumer use. History makes plain that professionals and families can easily accommodate to them; whether they *will* accommodate to them is a different issue. The example of the "low-fat diet" recommendation of the 1980s and early 1990s is an apt one. RDs and consumers adopted these low fat recommendations, the food industry responded with an avalanche of low- and no-fat products, and consumers swarmed to them. This was, however, a public health disaster, because consumers increased their caloric intake from sugars and highly-refined flours - and as a direct result we now as a nation confront epidemic overweight and obesity problems.

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4. Please do eliminate serving sizes and also mixing up grams and ounces; instead, use what consumers and families have grown up using and still do use every day - ounces, cups, teaspoons and tablespoons, slices - in other words, use the food terms that are used in the recipes in cookbooks, newspapers and magazines, and on radio, television and the internet. The Nutrition Facts Label has recognized this - it uses "1 cup" as its universal serving size. CNPP absolutely must follow this FDA consumer-friendly lead if the Food Guide Pyramid and related materials are to reach consumers with effective messages.

An example: the USDA has said that "a serving size is not a prescribed amount to eat," because is about one-half of the "serving" that its research concludes that consumers usually eat (USDA Misc. Pub. 1514). Nonetheless, the Food Guide Pyramid uses this unrealistic "serving size" throughout its consumer materials.

For an extensive commentary on the confusion surrounding consumer serving sizes, please see Gifford, KD, "Dietary Fats, Eating Guyides, and Public Policy: History, Critique, and Recommendations," American Journal of Medicine, Vol. 113(93) at 89S-106S.

5. Adding smaller subsets of illustrative food patterns is important for the credibility of the entire Food Guide Pyramid apparatus and for the credibility of the professionals who will take the new materials to the public. One good reason is that "one size does not it all" when it comes to the vast array of sizes, shapes, metabolic rates, activity levels, and food preferences of Americans. A second good reason is that while about three-quarters of consumers recognize the Pyramid, less than one-quarter understand it; the reason for this cognitive dissonance is that the Pyramid is not written for consumers but for professionals. To remove this dissonance, the Pyramid must use plain, everyday language, and simple, clear images. Then, and only then, will it encourage and enable consumers to turn away from unhealthy eating and drinking habits and towards healthy eating and drinking patterns.

On a related matter, there seems to be some confusion about the development and timing of the official release of an updated and revised Food Guide Pyramid. Page 1 of your Q&A dated September 10, 2003 says that the "posting of a second Federal Register notice to obtain public comment on the updated food guide graphic is planned for 2004." Page 2 of the Q&A says that "the updated pyramid will be released in 2005" and "will be consistent with the 2005 revision of the Dietary Guidelines." Veterans of the Dietary Guidelines process are aware that the final version of the Guidelines have actually been published in the year following the official date, i.e. 1995 in 1996, 2000 in 2001. We hope that you are taking this into your planning process; it would be a poor result if the Food Guide Pyramid was developed before the Dietary Guidelines Report is made final and approved by all the responsible officials.

On a second related matter, the slides of T. Britten need correcting. The 2000 Dietary Guidelines do not place emphasis on "lowering saturated fat;" they emphasize a diet "moderate in total fat" and "low in saturated fat and cholesterol. It is clear that the 2000 Dietary Guidelines intended specifically to move away from the unfortunate "low fat" guidelines of prior Guidelines, and CNPP should be hewing to this stricture.

Thank you again for this opportunity to comment.

Very truly yours,

K.D. Gifford/ dcm  
K. Dun Gifford  
President

cc: Sara Baer-Sinnott  
Executive Vice President

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October 20, 2003

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Food Guide Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Circle  
Room 1034  
Alexandria VA 22302

Dear Food Guide Reassessment Team:

As medical director of Kronos Optimal Health Company in Phoenix, Arizona, I am responsible for overseeing the development and implementation of optimal health products and services for corporations and consumers. Nutrition and exercise play important roles in our overall strategy of helping people live as healthy as possible for as long as possible. I am pleased to provide comments on the proposed Daily Food Intake Patterns and the accompanying technical support data tables. My comments are provided in accordance with the number in which you have indicated particular interests.

**Item 1**

I feel it is appropriate to use "sedentary, reference-sized individuals" in assigning target calorie levels for assessing the nutritional adequacy and moderation of each food intake pattern. It is difficult to use varying heights and weights in the context of keeping things simple. It is appropriate to use average height and ideal weight as the basis for calorie intake levels. I also agree it is important to avoid average weight, as most people who would follow these guidelines would err on the side of eating more rather than less.

**Item 2**

I agree with the appropriateness of the selection of nutritional goals for the daily food intake patterns, total fiber, and added sugar. However, I do not agree that food intake should be altered to achieve the Vitamin E intake recommended by the IOM. Additionally, it should be noted that a vitamin E supplement should be taken to make up for dietary deficiencies.

**Item 3**

I believe the proposed patterns are reasonable intakes for the various age/gender groups and that they are feasible. The science behind the recommendations is both strong and valid. The breakdown and difficulty comes in representing the appropriate intakes into a graphic representation that is both easy to understand and easy to implement. Families and individuals will be able to use these patterns if they are graphically represented in a comprehensible fashion.

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Item 4

It is more appropriate to use methods of measurement that are commonly used in the household. Most households do not have scales; therefore, there is no understanding of "ounces." A measurement by cups is probably easier to understand. Any measurements used should be used consistently, regardless if it is a measurement of cooked or uncooked food. I do not believe "servings" is an appropriate measure, either, as no one knows what that means. It may be more feasible to use some form of cup measurement in relation to a portion and a serving. It is also extremely important to match the language of food intake with the Nutrition Facts Food Labels. They must be equivalent to reduce confusion.

Item 5

I feel it is important to keep things as simple as possible. At first, I did not like the 12 calorie levels; I felt it was too complex. I now believe that it is the best method because it will provide specific guidance for appropriate food intake levels.

The selection of a smaller subset of patterns may be confusing. It may be more important to offer consumer materials that illustrate the overall concept of "calories in should equal calories out" to maintain weight. If you need to lose weight, you need to decrease calories and increase physical activity. If you need to gain weight, you need to increase calories and maintain physical activity. The consumer material should illustrate a graphic related to the types of foods that should be eaten, such as the Kronos "Circle of Nutrition" (enclosed for your review), which would be the size of a plate and have the plate divided in thirds to represent lean proteins, healthy fats, and complex carbohydrates and whole grains. To meet specifics for the individual, there should be a web-based calculator where you enter your race, height, weight, age, and activity level, and then what appears is where you fit into the 12 calorie intake levels and the types of foods consumed most by that specific population.

Thank you for the opportunity to provide comments on this important endeavor. If I may be of further assistance, don't hesitate to contact me.

Best of Health,

*Gary Bucher MD*

Gary Bucher MD  
Medical Director  
Kronos Optimal Health Company

Enclosure

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Bucher

"Eat for sustenance. Drink to re-hydrate your body."

PROTEINS TO AVOID



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Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

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October 21, 2003

Please rename the "Meat and Beans" group as the "Beans and Meat" group.

This would encourage people to eat more beans and less meat. People who do so consume more fiber, less cholesterol and less saturated fat.

These statistics are from "The Food Revolution" by John Robbins, page 19:

"Drop in heart disease for every 1 percent decrease in blood cholesterol: 3-4 percent (footnote 10).

Blood cholesterol level of vegetarians compared to non-vegetarians: 14 percent lower (footnote 11)."

Please take this step of renaming the "Meat and Beans" group the "Beans and Meat" group.

Respectfully,

Eric Jaffa

Eric Jaffa

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# The American Society for Clinical Nutrition, Inc.

THE CLINICAL DIVISION OF THE AMERICAN SOCIETY FOR NUTRITIONAL SCIENCES

## *The American Journal of Clinical Nutrition*



received  
10/21/03

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October 24, 2003

*President*  
Dale Alan Schoeller, PhD

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Food Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive  
Room 1034  
Alexandria, VA 22302

Dear Food Pyramid Reassessment Team:

The American Society for Clinical Nutrition (ASCN), with 1400 members, consisting primarily of MD's and/or PhD's engaged in clinical nutrition research and education, thanks you for the opportunity to comment on the proposed revisions to the daily food intake patterns that serve as the technical basis for the Food Guide Pyramid. Our journal, *The American Journal of Clinical Nutrition*, has the top impact factor of any peer-reviewed nutrition research and dietetics journal. Our comments are the following.

### Fruit and Vegetables (5-A-Day)

Table 1 presents the food pattern at each of 12 different calorie levels. At 1000, 1200, and 1400 calories/day, the food patterns described in Table 1 do not deliver the minimum "5-A-Day" servings of fruits and vegetables promoted by the federal government agencies. To remedy this problem, two steps could be taken:

- 1) Adjust the "additional fat" at each calorie level so that it will be equivalent to 17.25% of total calories (we obtained this figure by comparing the percentage of calories from "additional fat" at all 12 calorie levels and selecting the lowest value). At the three lowest calorie levels, this adjustment will "free up" calories from fat that can be used to boost vegetable and fruit intake.
- 2) Adjust the "added sugars" at 1000 calories to 2 teaspoons; at 1200 calories to 3 teaspoons; and at 1400 calories to 4 teaspoons/day for the same purpose as described above.
- 3) Individuals should be encouraged to consume fruits and vegetables that are deeply colored in order to achieve higher nutrient density especially at the lower calorie intakes.

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### **Milk Group**

In Table 1, the servings in the milk group at the three lowest calorie levels (1000, 1200, and 1400 calories) are 2 cups/day and at the other nine calories levels are 2 or 3 cups/day. ASCN recommends that the servings be changed to 3 or 4 cups/day. At the lower calorie levels, it will be necessary to emphasize the use of fat free choices in order to stay within the calorie levels. Table 5 assumes that only children ages 1 to 8 years are consuming at the three lowest calorie intakes. This assumption is incorrect as it is not unusual for many older Americans and adult females that are on diets to have calorie intakes in this range. Since the calcium AI for adults 19 through 50 years of age is 1,000 mg/day and 1,200 mg/day for those over 50 years of age, these individual would not receive adequate calcium unless they were consuming 3 to 4 cups/day from the milk group.

### **Portion Sizes Should be Consistent Across all Tools Guiding Consumer Intake**

As the development of the Food Guide Pyramid continues, ASCN strongly emphasizes the need to standardize portion sizes across all government tools that are intended to guide consumer food choices. The need to make portion sizes consistent between the Food Guide Pyramid and the Nutrition Facts Label on food products has never been more urgent. Inter-agency cooperation in achieving this goal should be a priority.

### **The Food Guide Should be Evidence-Based**

ASCN encourages the USDA to conduct the necessary consumer research to insure the Food Guide Pyramid is readily understood by the vast majority of Americans. Whether the Food Guide is a pyramid or some other shape, it should rely on icons and illustrations that are fully consumer tested to reflect the costs of food items as well as current consumption patterns and food availability. As a top priority, ASCN believes that consumer testing should verify that the Food Guide Pyramid influences the behavior of those who use it for weight management and to construct a healthier diet.

### **Exercise for Health and Weight Management**

The role of exercise in health and weight management should be graphically conveyed so that consumers understand the need to balance the food they eat with sufficient exercise to avoid weight gain and to stay healthy. There is consumer confusion about the Surgeon General's recommendation of 30 minutes per day of physical activity (for health) and the 2002 Institute of Medicine recommendation of 60 minutes of moderate intensity activity (for prevention of weight gain). The Food Guide Pyramid can clarify these two recommendations and the usefulness of each.

### **Guidance on Supplementation**

For some nutrients, guidance on supplementation should be offered. For example, as recommended in the IOM Dietary Reference Intakes Report on the B Vitamins released in 1998, adults over age 50 may need food fortified with vitamin B<sub>12</sub> or B<sub>12</sub> supplements and women who are capable of becoming pregnant need folate from fortified food or supplements.

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Vitamin E

ASCN does not believe that typical food intakes of vitamin E are far less than the RDA as stated in the Federal Register notice of September 11, 2003 on page 53538. As stated in the IOM Dietary Reference Intakes Report for Vitamin E released in 2000 on page 248, "These two studies indicate that Vitamin E intakes from CSFII and NHANES III surveys are probably underestimated even with the adjustment factor (0.8) and suggests that mean intakes of apparently healthy adults in the United States and Canada are likely to be above the RDA of 15 mg (34.9  $\mu$ mol)/day of  $\alpha$ -tocopherol."

Thank you again for the opportunity to comment on the proposed revisions to the daily food intake patterns that serve as the technical basis for the Food Guide Pyramid. Please contact us if we can be of further assistance.

Sincerely,



Dale Schoeller  
President



National Pecan Shellers Association

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October 24, 2003

Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

Dear Food Guide Pyramid Reassessment Team:

The National Pecan Shellers (NPSA) is a non-profit organization located in Atlanta, Georgia, whose members shell and process approximately 70% of the total U.S. pecan crop. NPSA supports its own nutritional research and education on pecans, and also supports nutrition research on other tree nuts through its membership in the International Tree Nut Council (INC). NPSA appreciates the opportunity to provide comments on proposed revisions to the daily food intake patterns that serve as the technical basis for the Food Guide Pyramid.

It is our view that the nutritional goals and daily food intake patterns that serve as the basis for the Food Guide Pyramid should serve as a tool to improve food intake for optimal health and disease prevention. Therefore, we recommend considering a separate category for legumes, nuts and seeds. We have specifically addressed below, several of the topics of particular interest to CNPP.

*Appropriateness of the selection of nutritional goals.*

The emphasis on low-fat diets is now under scrutiny as a more moderate approach has currently been taken to dietary fat recommendations. While lowering saturated fat to lower heart disease risk is well accepted, the amount and type of fat for healthy eating has become more important. A "moderate" dietary recommendation approach to total fat, emphasizing unsaturated fat food choices, is included in the USDA Dietary Guidelines for Americans 2000 (1). The 2000 American Heart Association (AHA) Dietary Guidelines (2) recommendation to "limit foods high in saturated fat and cholesterol; and substitute unsaturated fat from vegetables, fish, legumes, and nuts" includes nuts in a more predominant role than in the past. In May 2001, the National Institutes of Health's National Cholesterol Education Program Report (3) formalized its recommendation to keep total fat in the diet between 25-35% of calories. The recommendation for polyunsaturated fat in the diet is up to 10% of calories, and up to 20% of calories for monounsaturated fat. This is the first time monounsaturated fat has been officially

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“increased” as part of a recommended healthy eating plan. This has a major implication for nuts, which contain significant amounts of unsaturated fatty acids.

Earlier this year, the Food and Drug Administration’s (FDA) Task Force on Consumer Health Information for Better Nutrition released a report highlighting four key areas where FDA intends to focus its efforts on providing better nutrition information and health messages to consumers in the coming months. One such area includes, “The benefits of substituting nuts for other sources of saturated-fat-containing protein to help reduce the risk of heart disease (4).”

Shortly after FDA released its report, it also announced a new qualified health claim for nuts and heart disease. The claim is the result of a petition that was filed by the International Tree Nut Council and supported by NPSA. As part of the supporting documentation in the petition, a review article by Penny Kris-Etherton, PhD, RD, provides a thorough overview of the five large epidemiological and 11 clinical studies that document “frequent consumption of nuts decreases the risk of coronary heart disease” (5). Current status of research on unsaturated fats in nuts demonstrates that nut consumption can play a role in lowering coronary heart disease risk by decreasing both total cholesterol and LDL cholesterol levels. Research studies on nuts, which contain relatively high amounts of unsaturated fatty acids, have shown similar results in reducing risk factors associated with heart disease.

Epidemiological evidence from major population studies, which began with observations in Seventh Day Adventists (6), have documented the association between frequent nut consumption and lowered coronary heart disease risk (7). Clinical research trials on consumption of specific nuts including, almonds (8), walnuts (9), pecans (10), macadamias (11), hazelnuts (12), pistachios (13) and peanuts (14), show significant decreases in total cholesterol and LDL cholesterol levels. Important observations from these clinical studies include: subjects with normal or high cholesterol levels can achieve significant total and LDL cholesterol lowering; dietary regimens with increased unsaturated fats from nuts can be based on low fat recommendations (30% calories from fat) or a traditional high fat American diet (35-39% calories from fat) and show significant lowering of total and LDL cholesterol; significant blood cholesterol reduction of 5-12% for total cholesterol and 10-15% for LDL cholesterol.

Meeting vitamin and mineral recommendations is also critical for an individual to maintain good health and meet nutritional goals. The National Academy of Sciences has set a new precedent, setting daily requirements for vitamin and minerals beyond eliminating nutrient deficiency, to preventative or optimal health (15). Nutrient density of foods may become more important in food choices in order to meet micronutrient needs through foods, while keeping caloric intake in check. Food choices that include multiple nutrient benefits may become an important concept for consumers. In the meantime, the USDA, with the assistance and support of the INC and NPSA, recently conducted a comprehensive nutrient profile for micronutrients in nuts. The results show that nuts are valuable sources of significant amounts of copper, magnesium, manganese, phosphorus, selenium, and vitamins like thiamin, B-6 and E (16).

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While formal recommendations are not yet in place, the potential role of phytochemicals in health represents the leading edge in emerging science. This area is driven by research on chemical components found in foods that might have measurable health benefits like plant sterols for lowering cholesterol, or polyphenols for prevention of cancer. Nuts, a complex plant food, contain a wide variety of phytochemicals like phytosterols (beta-sitosterol), polyphenols (flavonoids, ellagic acid), phytoestrogens (isoflavonoids) and tocotrienols, that may play a significant role in heart disease and/or cancer prevention (17). Beta-sitosterol, for example, is one of several plant sterols found in nuts. It is implicated in cholesterol lowering, but more recently, cancer prevention (18). A collaborative, comprehensive analysis of phytochemical compounds is underway with the USDA, the Produce for Better Health Foundation and a number of commodity groups, including the INC and NPSA, to characterize these compounds in fruits, vegetables and nuts.

***Appropriateness of the proposed food intake patterns for educating Americans about healthful eating patterns.***

Over the past few years, nutrition experts and Oldways Preservation and Exchange Trust have begun to recommend a Mediterranean-like diet characterized by abundant plant foods (fruit, vegetables, breads, other forms of cereals, beans, nuts and seeds), fresh fruit, olive oil, dairy products (principally cheese and yogurt), fish and poultry consumed in low to moderate amounts, zero to four eggs consumed weekly, red meat consumed in low amounts, and wine consumed in low to moderate amounts, normally with meals (19). In a recent study published in the *New England Journal of Medicine*, researchers studied the effects of a Mediterranean diet on mortality in a population-based, prospective investigation involving 22,043 adults in Greece. Greater adherence to the traditional Mediterranean diet was associated with a significant reduction in total mortality. According to the authors, "After adjusting for age, sex, education, smoking status, BMI, waist-to-hip ratio, energy expenditure score and total energy intake, the only individual measures that were predictive of total mortality were the intake of fruits and nuts and the ratio of monounsaturated fats to saturated fats (20)."

Dietary consumption patterns from the Mediterranean region have historically shown the lowest recorded rates of chronic diseases and the highest adult life expectancy. It has also been shown that apparent benefits of the Mediterranean diet seem to be transferable to population groups from different origins and dietary habits, i.e., Australians (21). The Mediterranean diet as a secondary prevention measure is also much less expensive compared to other diet or drug treatments (22).

Government food consumption and nutrient intake data over the last ten years indicate that consumers are in the process of changing eating patterns, though somewhat misguided in their approach. While it appears that the fat message has taken hold and percentage of calories from fat has decreased to 32% of calories, total caloric intakes have risen (23). This increase in caloric consumption, together with limited amount of physical activity has contributed to increased incidence of obesity in the U.S. When it comes to dietary fat intake, recent consumer surveys including the Food Marketing Institute Trends Report (24) and the *Better Homes and Gardens* Consumer Survey 2000

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(25), demonstrate a decreased consumer interest/awareness in fat. It is possible that consumers are already making food choices with fat in mind so it is less of an issue for them. Interestingly, more consumers are on reduced fat and cholesterol diets than weight loss diets.

Recent studies do not implicate unsaturated fat or nuts in the diet as a contributor to weight gain. According to a recent paper published in the *American Journal of Clinical Nutrition*, epidemiologic studies indicate an inverse association between frequency of nut consumption and body mass index. No body weight changes were seen in well-controlled nut-feeding trials; and some studies with free-living subjects in which no constraints on body weight were imposed, showed a nonsignificant tendency to lower weight while on the nut diets (26). A report in the 2001 *Journal of International Obesity* showed that an energy-restricted diet containing 35% calories from fat (the extra fat coming from unsaturated fat foods such as peanuts, peanut butter, tree nuts and olive oil) produced similar improvements in body weight to a low-fat diet. And, an extra serving of vegetables were consumed by the high-unsaturated fat diet. Participation rates were significantly higher over an 18-month period for the high-unsaturated fat diet (27).

Current consumption of monounsaturated fat in the U.S. is 12.5% of calories and polyunsaturated fat is 6.4% of calories. Ironically, the three top contributors to monounsaturated fat in the US diet are beef, margarine and bakery goods, which do not contain significant amounts. Nuts are currently ranked 12<sup>th</sup> and oils are ranked 9<sup>th</sup>, although these foods contain primarily monounsaturated fat (23). To switch to an overall diet that contains close to 20% of total calories from monounsaturated fat, the inclusion of nuts is critical. However, there has also been a significant decline in consumers' awareness of unsaturated fat from over 40% in 1995 down to 25.5% in 2000 (25).

According to CSFII, in 1994-1996, 13 percent of U.S. consumers age 2 and over consumed tree nuts on any given day. Nuts are mostly consumed as snacks (51% of nuts consumed). Nut consumption is low compared to other protein sources. For example, nuts are eaten as a part of the evening meal only 14% of the time, demonstrating an opportunity to move nuts to the center of the plate (28).

It is critical to know where consumers are headed and whether they are ready to make changes in their eating habits for personal health, including eating nuts. Most surveys on consumer attitudes on nutrition and health show an overwhelmingly high interest in "ensuring good health." *Better Homes and Gardens* (25) reports that 85.5% of respondents work to prevent health problems, *HealthFocus* (29) reports 88% and *Prevention* (30) reports 79% of consumers want to ensure good health. In addition, according to *HealthFocus* (29), most consumers see a connection between nutrition and their health and they believe foods can offer benefits that reach beyond basic nutrition to disease prevention.

According to *Better Homes and Gardens* (25), 88% of consumers are serving more meatless meals for diet and health reasons. In a new report from Mintel Consumer Intelligence (31), research shows that the vegetarian food market will continue to grow for the next five years at a rate of 100% - 125%. While only 2.5% of American consumers are consistent vegetarians, it is estimated that 25% of consumers replace meat

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with meat alternatives at least for some meals. These "occasional vegetarians" may be making the switch for health purposes and may never intend to change their diets completely. Nonetheless, they are a major force in the growing interest in vegetarianism. What these "semi-vegetarians" need is the option to access more meat-free prepared meals and education—something nuts can provide.

The Food Guide pyramid can and should be used as a tool to help educate consumers about an optimal diet for disease prevention. A separate category in the pyramid, focusing on legumes, nuts and seeds would help educate consumers on the benefits of these important foods. It's important to note that although tree nuts are not legumes, they have a similar nutrient profile to peanuts, which are legumes (16). We recommend that tree nuts and peanuts be grouped together to help consumers move in the direction of plant-based diets.

*Appropriateness of using "cups" and "ounces" vs. servings in consumer materials to suggest daily amounts to choose from each food group and sub-group.*

In recent months there has been much discussion by health professionals and the media about portion size and its impact on weight. Since portion sizes have grown dramatically over the last decade, it is important to put serving sizes into perspective. In its recent announcement of the qualified health claim for nuts, the FDA stated:

"Scientific evidence suggests but does not prove that eating **1.5 ounces per day** of most nuts as part of a diet low in saturated fat and cholesterol may reduce the risk of heart disease. [See nutrition information for fat content.]"

Not surprisingly, most consumers do not know how much 1.5 ounces is, so NPSA suggests the equivalent of about 1/3 cup—which is the serving size used in the U.S. Dietary Guidelines.

Thank you for considering these comments, if we can provide you with additional information, please let me know.

Sincerely,



Russell A. Lemieux  
Executive Director  
National Pecan Shellers Association

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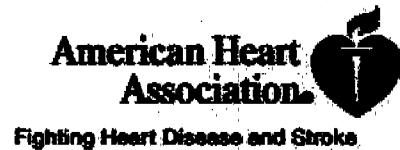
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October 24, 2003

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Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

Dear Sir or Madam:

The American Cancer Society, American Diabetes Association and the American Heart Association are pleased to provide comments concerning the USDA's proposed revisions to the daily food intake patterns that serve as the technical basis for the Food Guide Pyramid. These comments are in response to the Federal Register notice of Thursday, September 11, 2003 (v 68, #176).

The diseases represented by each of our organizations place a huge toll – both human and financial – on the American public. Each year, 1.5 million people die from cancer, diabetes, heart disease or stroke, representing 2 out of every 3 deaths.<sup>1</sup> Financially, it is estimated that these chronic diseases cost this country more than \$600 billion each year.<sup>2,3,4</sup> The cost to America for obesity is estimated at \$117 billion each year.<sup>5</sup> Because nutrition, physical activity and weight control play important roles in the development and management of chronic disease, we are pleased to work together to influence what forms the basis for sound nutrition policy and consumer education in the United States.

We applaud the USDA in keeping with its goals to provide the best available science-based information about healthy dietary patterns and to influence dietary practice among consumers. This parallels what each of our organizations has done throughout our histories, not only to decrease disease risk but to improve disease management, as well. It is this experience and commitment to improving healthy lifestyles and decreasing chronic disease risk that are reflected in the comments and concerns below.

We first address the five topics of particular interest to the USDA's Center for Nutrition Policy and Promotion (CNPP), and then address several other topics of concern in this area:

1. Appropriateness of using *sedentary, reference-sized individuals* in assigning target calorie levels (Table 2) for assessing the nutritional adequacy and moderation of each food intake pattern.
  - With the increase in obesity in the American population, we support the USDA's proposal to use sedentary individuals at their reference weights in assigning target calorie levels. Using reference instead of median weight will better reflect caloric requirements for the general US population and aid in educational efforts on weight management.
2. Appropriateness of the *selection of nutritional goals* for the daily food intake patterns.
  - We support USDA's selection of nutrition goals for the daily food intake patterns (Table 3).
3. Appropriateness of the proposed *food intake patterns for educating Americans* about healthful eating patterns:

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- For each food group, we suggest that there be emphasis placed on nutrient quality and that there be a way to identify nutrient dense foods within a food group. For example, whole grains should be distinguished from and emphasized over refined or processed grains; whole fruits and vegetables should be emphasized over juice; lean protein sources should be emphasized over those higher in saturated fat.

To accomplish this, icons could be used within a variety of ways: all icons within the fruit and vegetable category should represent nutrient-dense choices (for example, replace apples, grapes and iceberg lettuce with peaches, mangoes, kiwi and red cabbage); icons for all dairy products should depict lowfat and fat-free choices (for example, a glass of milk that says "lowfat" across it); larger icons should be used to depict healthier choices within the meat group (ie fish and poultry icons larger than red meat).

- Preferably, dessert items such as frozen yogurt and other dairy desserts would not be included in the milk group but rather in another category containing sweets, fried foods, etc that are to be consumed infrequently.
- The USDA indicates that "Pyramid serving sizes within a group must be approximately equivalent in both calories and nutrients" (FR-68 p53539; 2<sup>nd</sup> column). The calories and macronutrients (in terms of 1/2 cup servings) are widely discrepant between the dark-green and deep-yellow vegetable subgroups and the legumes and starchy vegetable subgroups. We suggest that the starchy vegetables and the legumes be shifted from the vegetables group to the grains group (with a name change for the group to indicate the additions). The calories and nutrients from a serving of starchy vegetables or legumes (1/2 cup) are a much better "equivalency" for the grains group than the vegetables group, whether based on all foods or most commonly used foods.<sup>6</sup>

The most recent update (2003) of the American Diabetes Association's Exchange Lists for Meal Planning again uses this designation for these two food groups and found it to be a good fit for both calories and nutrients.<sup>7</sup> We strongly encourage the CNPP to recalculate the vegetable and grains groups in Table 4 to reflect this change and we feel sure you will find the same result.

Finally, with obesity so prevalent in the US in nearly all age groups, consumer perception of portions needs to be downsized. Grouping starchy vegetables with grains may help consumer better identify sources of calories in their diets.

- "Added fats" and "Added sugars" are both very difficult to comprehend in terms of food choices because the values given incorporate fat (or sugar) that occurs as part of food items intrinsically and fat (or sugar) that the consumer might choose to add. This leads to a very misleading presentation, suggesting it is "healthy" to add much more fat (or sugar) than the intended. Because there is increasing scientific evidence that the *type* of fat in the diet plays more of a role in chronic disease development than *total* amount of fat, emphasis should be placed on healthier fat choices (monounsaturated, omega three and polyunsaturated fatty acids), both within the "Added fats" and other relevant food groups. If it is decided to retain the "Added fats" category, emphasize liquid oils and margarine, and nuts and seeds over solid fats by listing them first in this section. In addition, separate margarine from oils due to trans-fat content of the former, and emphasize soft margarines over stick versions. Within the "Added sugars" category, it should be stressed that the amounts of added sugars are **not** specific recommendations for amounts of added sugars to consume.
4. Appropriateness of using "cups" and "ounces" vs. "servings" in consumer materials to suggest daily amounts to choose from each food group and subgroup

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- Given the general misperception among the public of what constitutes appropriate portion sizes, the revised Food Guide Pyramid must attempt to communicate this concept in a meaningful way. Pyramid graphics should include representation of appropriate portion sizes, and supporting collateral for consumers should explicitly show how today's "usual serving sizes" (ie larger than appropriate/standard) relate to recommended intake. See the enclosed brochure titled *First Step in Meal Planning* that has incorporated serving sizes as well as practical tips in selecting the most nutrient dense choices in each category.
- We believe that in most cases, recommended total daily amounts to choose from each food group should be expressed in cups or ounces per day instead of servings. Exceptions to this include whole fruits and bread products, which do not convert easily to cup or ounce measurements and would likely cause confusion if the attempt is made to convey these items this way. There is great variation in the serving suggestions on the Nutrition Facts Label and standard reference amounts for the Food Guide Pyramid, and we encourage USDA to determine how best to develop consistency in serving sizes across Food Guide Pyramid recommendations and the Nutrition Facts Label.

By indicating the total amounts for a day in cups or ounces rather than by total servings for most food groups, consumers will be better able to compare their actual intake to the recommendations. In addition, we feel it is important to make the statement that the upper range of recommended intake for foods within a category are for those individuals who require a higher caloric level based on age and/or physical activity level.

#### 5 Selection of appropriate illustrative food patterns for various consumer materials.

- The publication of all twelve calorie ranges may be useful in the technical documents for professionals, however, we suggest using five or six calorie ranges in the various consumer materials. For example dividing the ranges into categories such as 1,000-1399, 1400-1799, 1800-2199, 2200-2599, 2600-2900, and 3000+.

#### General comments related to revision of the Food Guide Pyramid.

- The foundation for recommendations made within the revised Food Guide Pyramid should first and foremost be the available scientific evidence. This will help ensure the credibility of the Pyramid recommendations and garner the support of the scientific and health communities.
- With regard to a reshaping of the pyramid, we would suggest conducting focus group testing to identify how consumers group foods and which graphic representation would most effectively convey the nutritional messages to help consumers assess and improve their diets.

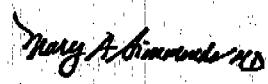
In clinical practice, it is often helpful to use a circle or plate representation to provide a visual of food choices. This method may be useful for the general public as well. Such a visual can be easily related to proportions of a meal from different food groups. Additionally, use of a similar graphic may be used across age groups and cultures.

- We would like to emphasize the importance of encouraging physical activity to promote general good health as well as its role in the prevention of diabetes, heart disease and cancer and other chronic health conditions. Balancing food intake with daily physical activity is essential in promoting health and should be considered for inclusion in the new Food Guide Pyramid.

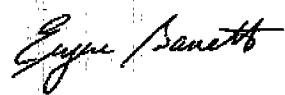
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We appreciate the USDA's efforts to evaluate and revise the Food Guide Pyramid and for allowing participation in the process.

Sincerely,



Mary A. Simmonds, MD, FACP  
President  
American Cancer Society



Eugene J. Barrett, MD, PhD  
President  
American Diabetes Association



Augustus O. Grant, MD, PhD, FAHA  
President  
American Heart Association

Fig 5  
Simmonds

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3. American Cancer Society (ACS). *Cancer Facts & Figures 2003*. Atlanta, GA: ACS, 2003.
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7. Wheeler ML. Nutrient database for the 2003 exchange lists for meal planning. *J Am Diet Assoc* 103:894-920, 2003.

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Receipt

# USA RICE

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## FEDERATION®

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KT

October 24, 2003

Eric J. Hentges  
Executive Director  
USDA Center for Nutrition Policy and Promotion  
Food Guide Pyramid Reassessment Team  
3101 Park Center Drive, Room 1034  
Alexandria VA 22302

Dear Dr. Hentges:

Thank you for the opportunity to comment on CNPP's Proposed Daily Food Intake Patterns, which serve as the technical basis for the Food Guide Pyramid.

The USA Rice Federation is a national trade association representing all segments of the U.S. rice industry. Through a wide variety of consumer research and education programs, we have gained a keen insight and understanding of consumer preferences on issues regarding dietary choices, as well as food preparation and consumption. Our experience and knowledge, coupled with research from other expert sources, guides our response on certain of CNPP's proposed revisions.

The Tables presented in the CNPP document are very impressive. It is apparent much time, thought and hard work were dedicated to their creation. Issues we would like to comment on involve a few technical points, as well as points of view we feel need to be addressed:

1. Our primary goal must be to focus on improvement of nutrition in America. This can only be achieved with a healthy balance of all nutrients. In Table 1, "Proposed Daily Food Intake Patterns", Page 1 allows for "Additional Fats" and "Added Sugars" at each calorie level. As calories increase, however, so do percentages of fats and sugars. For example, at 1600 calories, allowed sugars and fats total 24.5% of the day's calories. At 3200 calories, sugars and fats represent 35.4% of the total day's calories. Wouldn't it be more balanced to encourage increased consumption from healthier food groups?
2. In Table 3, "Nutritional Goals for Proposed Daily Food Intake Patterns, Goals for Macronutrients", Page 3 depicts a double column under "Carbohydrate". The first column, entitled "RDA", lists the 1989 Recommended Dietary Allowances of the necessary glucose

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required by the brain to function. It was estimated to be 130 grams per day, regardless of the person's age, gender or overall caloric requirements.

The column next to RDA is AMDR, representing the Acceptable Macronutrient Distribution Range, which bases its values as percentages of total daily calories in order to maintain body weight. Considering the wide array of Daily Calories considered in the proposed Food Guidelines (1000-3200 calories per day), the AMDR allows for a range of 112-520 grams of Carbohydrate per day. This is a more authentic reflection of the actual intake of a large population group, therefore it is much more realistic to utilize the AMDR 45-65 percent range of total daily calories it allows. For simplicity sake, we support the average National Academy of Science recommendation for carbohydrates, 55 percent of calories, rather than providing a range of 45-65 percent.

3. Table 4, "Nutrient Profiles of Food Guide Pyramid Food Groups and Subgroups", appears to have an error on Page 3 under Macronutrients. The grains group shows a positive value for cholesterol. That is highly unlikely for foods that don't sport livers to have cholesterol.
4. As USDA points out, using the term "serving" to mean a standardized amount of food is widely misunderstood by consumers. Therefore we recommend using "cups" for cooked rice, pasta, and cereal. We would discourage the use of ounces for cooked rice, cereal or pasta as this is not practical for consumers.
5. The recommendation for half of the daily servings of grains to be whole grains is not consistent with current recommendations of a minimum of three servings a day and is not realistic or practical. We recommend you continue with the commonly recognized level of three servings per day from whole grains.
6. Finally, we urge the USDA to remember that a consumer education campaign must be simple and easy to understand. While we support the approach of multiple caloric levels for dietitians and nutrition professionals, the use of twelve distinct calorie levels would be confusing and overly detailed, requiring significant time for consumers to discern. This approach is much too complicated, and consumers might ignore calorie levels altogether. Perhaps fewer, more familiar caloric levels (1200, 1500, 1800, 2000, 2500 etc.) would be acceptable or, since the minimum caloric level of 1600 calories is necessary for the current Food Guide Pyramid, that number could be used as a base, with additional servings added as needed for higher caloric levels.

Today two-thirds of U.S. consumers are eating rice once a week, 85 percent have rice at least twice a month, and 90 percent are eating rice in restaurants, up from 75 percent in 1992. Clearly rice is a mainstay of the diet in the U.S. and worldwide. Its taste, versatility, nutritional value, convenience, and low cost make rice a popular choice with consumers nationwide and of different cultural backgrounds.

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In your FGP goals to promote overall health, reflect up-to-date nutrition, develop a realistic tool that includes common foods reflective of food consumption patterns, and is practical, evolutionary, and allows maximum flexibility, rice fits.

Thank you for your consideration of the U.S. rice industry's views and comments.

Sincerely,

  
Stuart Proctor  
President and CEO  
USA Rice Federation

1992 Browning  
American Institute  
for Cancer Research

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Food Guide Pyramid Reassessment Team  
USDA Center for Nutrition Policy and Promotion  
3101 Park Center Drive, Room 1034  
Alexandria, VA 22302

October 24, 2003

Dear Members of the Pyramid Reassessment Team:

In January of 1999, the American Institute for Cancer Research (AICR) submitted to the Dietary Guidelines Advisory Committee (DGAC) the following recommendations for changes to the Dietary Guidelines for Americans 2000:

1. Give first priority to plant-based foods;
2. Emphasize variety and minimal processing;
3. Emphasize consumption of whole foods and caution against use of nutrient supplements as a primary strategy for preventing disease;
4. In place of recommendations on fats, caution against use of excessive added fat, salt and sugar.

These recommendations – many of which were adopted by the DGAC – were based on conclusions of the expert panel that authored AICR's landmark report on the link between diet and cancer entitled *Food Nutrition and Prevention of Cancer: A Global Perspective*. This exhaustive 650-page report examined over 4,500 studies relating to all aspects of the diet-cancer link.

The report weighed the international scientific evidence and issued a list of simple guidelines that, if adopted, could reduce worldwide cancer rates by an estimated 30 to 40 percent. (See pp. 522-523.) Since the report was published, its conclusions have been consulted and adopted by governments, official agencies, research scientists, teachers, health professionals, community groups, families and individuals worldwide.

AICR and its global affiliate, the World Cancer Research Fund International, have recently embarked upon the creation of a second report, which will again review the evidence for connections between lifestyle (diet, physical activity, weight management) and cancer prevention. This second report is scheduled for publication in 2006.

Until that time, the conclusions found in the original AICR expert panel report remain the most comprehensive and authoritative guidelines for cancer prevention ever undertaken.

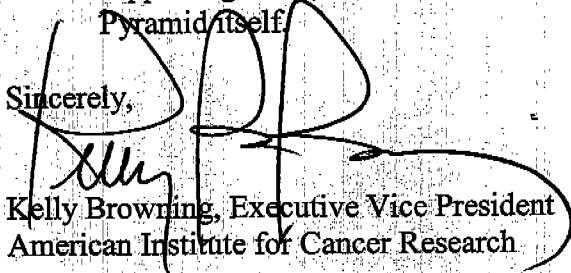
As the Food Guide Pyramid Reassessment Team considers changes to the Pyramid, AICR wishes to direct its attention to evidence contained in *Food, Nutrition and the*

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*Prevention of Cancer: A Global Perspective.* Note that adopting the recommendations listed below would amount to a simple "fine-tuning" of the current Pyramid.

1. **Explicitly recommend that whole grains be selected *over* refined grain products.** (See Recommendation 5 on p. 513, and the evidence supporting the recommendation in Chapter 6.1.)
2. **Clearly distinguish between plant-based protein and animal sources.** The AICR report links consumption of red meat with cancers of the colon and rectum, pancreas, breast, prostate and kidney. Animal fat is linked with cancers of the lung, colon, rectum, breast, endometrium and prostate. (See Recommendation 7 on p. 515 and the evidence supporting this recommendation in Chapter 6.6.) **Place more emphasis on beans, nuts and seeds. Lean protein should be encouraged** (see discussion of saturated fat, p. 392.) **Emphasize lowfat or nonfat dairy products** for same reason.
3. **Distinguish between fats and oils of animal origin and vegetable oils with a favorable fatty acid profile.** (Again, see discussion of saturated fat, p. 392.)
4. Because **physical activity is an essential part of calorie balance and is linked to lower cancer risk** (see Recommendations 2 and 3 on p. 513 and the evidence supporting these recommendations in Chapter 5.1) it should be listed on the Pyramid itself.

Sincerely,



Kelly Browning, Executive Vice President  
American Institute for Cancer Research